Fairview Northland Medical Center
Princeton, MN

Sharing Our Best Practice

Core Measure Meeting
October 9, 2012
Quality Reporting and Improvement

Fairview Northland Success Story

One of 6 - Fairview Hospitals
Princeton, MN
North to Rogers on I-94
then North on 169

Licensed 54 beds
Average Monthly
- Inpatient Discharges – 150
- Length of Stay – 2.56
- Surgical Patients – 34 –IP; 154-OP
- ED Visits – 1,367
Today—Shared Learning, our best

My Report Card

Bolus Vs. Harvard

Model VBP FY2014 Worksheet

<table>
<thead>
<tr>
<th>Inpatient Process Measures</th>
<th>Input</th>
<th>Input</th>
<th>Output</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Your Baseline</td>
<td>Your Performance</td>
<td>National Clinical Data Performance Standard</td>
<td>Improvement</td>
</tr>
<tr>
<td></td>
<td>Apr 2010 - Dec 2010</td>
<td>Apr 2011 - Dec 2011</td>
<td>Performance Threshold</td>
<td></td>
</tr>
<tr>
<td>HF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalizations</td>
<td>227</td>
<td>231</td>
<td>100.0%</td>
<td>227</td>
</tr>
<tr>
<td>PNEUMONIA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia Deaths in Hospital</td>
<td>2</td>
<td>0</td>
<td>100.0%</td>
<td>2</td>
</tr>
<tr>
<td>SCIP (Surgical Care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-1: Prophylactic Antibiotics Prior to Catheter Placement</td>
<td>133</td>
<td>133</td>
<td>100.0%</td>
<td>133</td>
</tr>
<tr>
<td>SCIP-2: Prophylactic Antibiotics Prior to Catheter Placement</td>
<td>133</td>
<td>133</td>
<td>100.0%</td>
<td>133</td>
</tr>
<tr>
<td>SCIP-3: Prophylactic Antibiotics Prior to Catheter Placement</td>
<td>133</td>
<td>133</td>
<td>100.0%</td>
<td>133</td>
</tr>
<tr>
<td>SCIP-4: Prophylactic Antibiotics Prior to Catheter Placement</td>
<td>133</td>
<td>133</td>
<td>100.0%</td>
<td>133</td>
</tr>
<tr>
<td>Your VBP Process Earned Points</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your VBP Process Potential Points</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your VBP Process Domain Score (Your Earned Points/Your Potential Earned Points)</td>
<td>40 / 100 = 40.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Today—Shared Learning, our best**

1. Prepare everyone 6 months in advance of a revised/new measure.

2. Get to the Root Cause in every missed measure, and widely execute the resulting improvement plan.

3. Highly effective teams can *make or break* it – one example

4. Goal = 100% -- Every case counts. Examples of accountability & structure

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1. Prepare everyone 6 months in advance of a revised/new measure.

- Monitor for changes:
  - Stratis Health - [http://www.stratishealth.org/providers/data/hospitalrep.html](http://www.stratishealth.org/providers/data/hospitalrep.html)
  - Quality Net Exchange - [https://www.qualitynet.org/](https://www.qualitynet.org/)
  - Premierinc - [https://premierconnect.premierinc.com/wps/myportal/mypremier](https://premierconnect.premierinc.com/wps/myportal/mypremier)

- Gather your implementation team:
  1. Abstractor + Leader Champion + Nurse Clinician/educator
  2. Goal: Understand the definition (abstractor)
  3. Goal: Translate the definition to workflow --- What needs to change to make it happen? How will we watch to give feedback, real time? (Leader Champion)
  4. Goal: Create/modify staff tools, and design the implementation plan & date (educator)
1. Prepare everyone 6 months in advance of a revised/new measure.

We expect of Caregivers and Physicians:

- Understand CMS measures, and
- Use the tools consistently
- Include “CMS measure” info in hand-offs

Rule of Thumb--- Change is easier if you embed it into current workflows

- Hand-off communication
- Order sets/protocols
- Change in diagnosis

We expect of Area Charge Nurses & Supervisors:

- Understand their role to safe catch & mentor the healthcare team, and
- Use the tools consistently

Rule of Thumb---Humans need feedback to change

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**New CMS inpatient Measures – Proposed**

Open Comment Period until June 25, 2012

Effective January 2013 discharges

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticoagulation Therapy for Atrial Fibrillation (STK-3)</strong></td>
<td>Prescribe anticoagulation therapy at hospital discharge</td>
</tr>
<tr>
<td><strong>Mechanical Thrombectomy for Acute Ischemic Stroke (STK-4)</strong></td>
<td>Administer mechanical thrombectomy therapy to adult patient who had a presumed ischemic stroke and arrived in the emergency department greater than 24 hours but less than 24 hours (less than 90 minutes) of time last known well</td>
</tr>
<tr>
<td><strong>Anticoagulation Therapy by the end of hospital day 2 (STK-9)</strong></td>
<td>Administer anticoagulation therapy to adult patients who had a presumed ischemic stroke and arrived in the emergency department greater than 24 hours but less than 24 hours (less than 90 minutes) of time last known well</td>
</tr>
</tbody>
</table>

Definitions are organized to help the Implementation Team to plan
Nurses are given Checklists as reminders

Training materials & Reference must be clear to Who does what
1. Prepare 6 months in advance of a revised/new measure – How?

*EXAMPLE:* VTE for medical patients -- January 1, 2013 effective date

Ask yourself:
1. Is this New? How big of a change?
2. How well do we score (pre-change)?

Plan: *Set your dates by planning backwards*

- We will need Data for staff feedback -- Nov. & Dec.
- We will need Data to test abstraction -- Oct.
- This means Staff education; Reference tools & checklist updates --- Sept. & Nov.

Rule of Thumb--- It takes 5-6 months from design to feedback on performance post change

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**Goal:** Share Our Best of the Best Practices

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4. Goal = 100% -- Every case counts. Examples of accountability & structure
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Charge Nurse-
disCOVERs a miss
= Fix it now

AbstracTOR-
disCOVERs a miss
= Fix it for
the next time

Rule of Thumb—Improvement is like Fruit. Served fresh everyone wants a bite. The older it gets, no one wants it. Presentation is important.

2. Get to the Root Cause in every missed measure, and widely execute the resulting improvement plan.

Understand it first
Stand in the shoes of the caregiver to understand.
• Ask why 5 times
• Analyze contributing factors: systems, design of process, instructions, culture & teamwork, materials

Fix it, safe catch
• Checklists at discharge
• Add explanatory documentation (contraindications)
• Consult with the abstractor
2. Get to the Root Cause in every missed measure, and widely execute the resulting improvement plan.

INVESTIGATION & IMMEDIATE ACTION
- What contributed or caused it?
- What would it take to happen again in the future (may need expert help)?
- Do we have the people who do the work, looking at this?
- What will it take to prevent it reoccurring (process, orders, training, other experts to help identify what happened)?

Communicate in SBAR:
- [Findings]
- [Recommendations for improvement]
- [Actions you already started and what is left]
- [Communications you Did and what is left]

ACTION PLAN & COMMUNICATION - all Clinical Leadership
- Evaluate the investigation & immediate action plan.
- Was it on target? Anyone or anything missed?
- Are you confident that just the immediate action will prevent reoccurrence?

RCA: SBAR Communication by eMail

RCA EMAIL: Missed Measures IMM OB 7/9/12

WHAT WENT WRONG (Abstractor):
Situation: Performance Measure: Pneumococcal Immunization (IMM-1)
Background: 23 year old female (MRN + area + dates) presented with IUP at 36+1 EGA with known IUGR and lagging AC. NST barely reactive and BPP 4/8. Proceed with LTCS. Hx of Asthma - intermittent.
Assessment: Appropriately assessed on admission for immunization status. Contraindication of "currently pregnant" only applies until delivery, must be reassessed at discharge when no longer pregnant. No additional documentation that immunization administered prior to discharge.
Recommendation: Per CMS Specifications: Acute care hospitalized inpatients between 19 and 64 who are considered high risk(aphasia) should be screened and vaccinated prior to discharge if indicated. If no vaccine administered during the current hospitalization, should have documentation that pneumococcal vaccine had been previously administered, contraindications to vaccine or indication that the patient declined/refused the vaccine.

INVESTIGATION & IMMEDIATE ACTION: (Leader Champion)
S/B: as above
A: Patient was not reassessed after delivery. Staff education regarding addressing immunizations was done 7/15, after this event occurred.
R: Continue with current plans for monitoring immunization status and methods of ensuring compliance.

ACTION PLAN & COMMUNICATION - FN wide (Area Director)-- Agrees with plan
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**Highly effective teams are magic – one example**

The Opportunity: OP-23, Head CT, Imaging
- How do we think differently? - Expand your team (include remote roles)

1st level improvement: Identify
- **Early identification.** Flow chart it - Considering time of day, means of arrival, screening process

2nd level improvement: Get to test
- Arrivals by ambulance stay on the gurney to imaging. "We're just missing time."

3rd level improvement: Report TAT
- Standardize workflow for after hours (remote) Radiologists

4th level improvement: Report TAT
- **System change**- Real time results communication (Radiant)
Attention to accountability & structure - one example

Most Important when forming a focused improvement team:
1. Identify a Leader champion --- Hold them accountable for results

2. Team up with the abstractor and a nurse expert in workflow and staff education ---- Align your best talents expect change “today”

3. Engage the caregivers that do the work – Ask, listen, change it today
   • Measure what’s important-- Communicate it everywhere, every time
   • Give feedback; Acknowledgement -- Show it is important

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Examples of accountability & structure

Most Important:

- Align your leaders to what’s important -- *VBP metrics*
- Design cascading goals to connect to purpose.
- Set shared goals with individual and group targets
  - *Achieved & Exceed targets*
  - *Monthly dashboards to analyze performance*

CMS Roll up (IP & OP) Goal: Achieve 95.3% (ACS) or higher
Contact Information

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Thank you for inviting us!